`Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

HOWARD DILLARD, JR, MD
3100 TIMMONS LANE, STE 250
HOUSTON, TX 77027

Respondent Name

SERVICE LLOYDS INSURANCE CO

Carrier's Austin Representative Box

Box Number 42

MFDR Tracking Number

M4-11-4261-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "CARRIER REFUSES TO PAY FULL AMOUNT DUE FOR SERVICES RENDERED EVEN AFTER A REQUEST FOR RECONSIDERATION WAS SUBMITTED."

Amount in Dispute: $300.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Rule 134.204(j)(4)(C) states, "For musculoskeletal body areas, the examining doctor may bill for a maximum of three body areas." Subsection (i) defines "Musculoskeletal body areas" are spine and pelvis, upper extremities and hands, and, lower extremities (including feet). The provider only submitted diagnoses codes for the spine and upper extremity musculoskeletal areas. Therefore reimbursement was made based on the billing submitted. Had the provider included a diagnoses [sic] for injuries to the lower extremities, the Rules would have allowed reimbursement of $150.00 for this additional body area."

Response Submitted by: Service Lloyds via Harris & Harris, 5900 Southwest Parkway, Building II, Suite 100, Austin, TX 78735

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 15, 2011	99456-W5-WP	$300.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.204 sets out Medical Fee Guidelines for workers' compensation specific services effective March 1, 2008.

3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   Explanation of benefits dated May 20, 2011
   - ORC –See Additional Information
   - W1 – Workers' Compensation State Fee Schedule Adj
   - MMI LUNG/RIB COMPENSABLE INJURY DRE, NON COMPENSABLE INJURY NOT AT MMI

   Explanation of benefits dated June 15, 2011
   - 505 – Maximum units exceeded, payment adjusted
   - 193 – Original payment decision maintained
   - W1 – Workers' Compensation State Fee Schedule Adj
   - W3 – Additional payment on appeal/reconsideration
   - Rule 134.202 For musculoskeletal body areas, the examining doctor may bill for a maximum of three body areas. You only have 2 musculoskeletal diagnosis codes on our bill. DDE/MMI, IR, 2 BODY AREAS

   Explanation of benefits dated July 01, 2011
   - 168 – No additional allowance recommended
   - 193 – Original payment decision maintained

   Explanation of benefits dated July 06, 2011
   - 168 – No additional allowance recommended
   - 193 – Original payment decision maintained
   - ORC –See Additional Information
   - W1 – Workers' Compensation State Fee Schedule Adj
   - Rule 134.202 For musculoskeletal body areas, the examining doctor may bill for a maximum of three body areas. You only have 2 musculoskeletal diagnosis codes on our bill. DDE/MMI, IR, 2 BODY AREAS

Issues

1. Has the Designated Doctor (DD) examination been reimbursed appropriately per 28 Texas Administrative Code §134.204?
2. Is the requestor entitled to additional reimbursement for disputed services under 28 Texas Administrative Code §134.204?

Findings

1. The requestor submitted a billing for the DD examination Maximum Medical Improvement/Impairment Rating (MMI/IR) services for 4 body area/unit in box 24G of the CMS-1500 for $1,100.00 and billed with CPT code 99456-W5-WP. Review of the documentation supports that MMI was assigned on the compensable injury and per 28 Texas Administrative Code §134.204(j)(3)(C), the Maximum Allowable Reimbursement (MAR) for MMI is $350.00. The rib and lung injury are the compensable areas claimed as rated and as part of a multiple impairment assessment, additional non-compensable areas are claimed as rated as well, including lumbar and cervical (spinal region), right shoulder (upper extremity), and right knee (lower extremity) and the head as a non-musculoskeletal body area. The additional areas are not ratable as the injured worker is not at MMI for those areas and the narrative states, "for the non compensable injury the examinee has not reached his point of MMI at this time." Therefore, there is no reimbursement for any impairment rating that cannot be done when the injured worker has not reached MMI. However, documentation does support the IR per AMA Guides to the Evaluation of Permanent Impairment, 4th Edition for the two non musculoskeletal conditions of the rib and lung is per 28 Texas Administrative Code §134.204 (j)(4)(D)(iv) and (v) and has a MAR of $150.00 x 2 = $300.00. The combined MAR for the MMI and IR exams is $650.00. The respondent has reimbursed the amount of $800.00 for the disputed CPT code 99456-W5-WP.
2. As the respondent has already reimbursed the amount of $800.00 for the disputed CPT code 99456-W5-WP. Therefore, the requestor is not entitled to additional reimbursement.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		February 13, 2012
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.
Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.